DEMO General Certification Overview

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Introduction

Welcome

What You Will Learn

The purpose of this course is to prepare you to be a disability examiner. You will be provided with best practices used to prepare for, conduct, and document a C&P examination according to Disability Examination Management Office (DEMO) guidelines.

This course is required for certification as a disability examiner. Additional courses are required in addition to this course in order to conduct five different kinds of specialty examinations. Additional courses required for specialty examination certifications are listed on the End of Course Activities page.

This basic certification training is designed to help you master the following concepts:

Understand the difference between a clinical examination for treatment purposes and a C&P disability examination.

Recall terminology and important legal concepts pertaining to C&P disability examinations.

Identify best practices used to prepare for, conduct, and document a disability examination.

Recognize best practices for guiding the Veteran or Servicemember through the examination and properly answering questions.

Target Audience

This training is designed for physicians, nurses, psychologists, Integrated Disability Evaluation System (IDES) providers and other health care providers seeking certification to conduct C&P examinations.

Length of the Course

This course will take you approximately one hour to complete.

Please complete each lesson in the order presented. By doing so, you will be able to build on that knowledge in subsequent lessons.

Compensation and Pension Terminology

This course will provide basic information about the context that you will work within as a disability examiner. This new situation relies on a lot of terms and definitions. For this reason, some terms in the onscreen text will be linked.

The same Glossary can be accessed in the Resources section of this course. Definitions will be linked to the page where they first appeared so that you can access the term used in context.

Course Objectives

The terminal learning objective (TLO) for this course is as follows:

Given a Request for Examination form, condition-specific Disability Benefits Questionnaire(s) (DBQ) or other documentation protocol(s), and any other applicable evidence, the disability examiner will be able to recall the general process for conducting and documenting a Compensation and Pension (C&P) disability examination that meets adjudication requirements for the Veterans Benefits Administration (VBA) and the Board of Veterans' Appeals (BVA).

To help you meet this objective, there are eight enabling learning objectives. When you complete this course, you should be able to:

- Recall two aspects in which a clinical examination for treatment is different from a disability examination
- Describe the disability examiner's role in the C&P claims process
- Define exam priorities found on Request for Examination forms
- Define C&P legal terms used on Request for Examination forms
- Identify the information needed from a disability examination after reviewing a Request for Examination form and the DBQ(s) or other documentation protocols listed on the Request
- List the correct protocols for handling and using Veterans' Claims files
- Recognize best practices for opening, conducting, and closing a C&P examination
- Identify best practices for documenting a C&P examination for VBA and BVA adjudication purposes

The standards for this course are found in federal regulations; VA directives; and manuals from Veterans Health Administration (VHA), Veterans Benefits Administration (VBA), and the Board of Veterans' Appeals (BVA); and in guidance from the Disability Examination Management Office (DEMO).

Introduction

Imagine that you are on the witness stand in a courtroom. You are an expert witness who will provide testimony in order to help the judge come to a fair determination. The judge leans toward you as you speak. Seated in front of you is a disabled Veteran or Servicemember whose case is being examined. Both are paying close attention as you speak, because what you say is part of the legal record that will determine the outcome for this case.

Your role as a disability examiner is not much different than testifying from the witness stand. You will use your clinical expertise to provide information for adjudication purposes. How well you conduct and report each disability examination will impact others in addition to the Veteran or Servicemember you examine.

How Is a C&P Disability Examination Different?

Learning Objective

You are likely to have experience examining patients for treatment purposes. As a disability examiner, you will perform examinations that have a different purpose than a treatment examination, and a different audience for the documentation that you produce from the exam.

When you complete this lesson, you should be able to recall two aspects in which a clinical examination for treatment is different from a disability examination.

A Treatment Exam vs. a Disability Exam

While ultimately a Veteran or Servicemember that you examine is the beneficiary of either a treatment or a disability examination, there are important differences in two areas:

The purpose of the exam

The audience for the exam report

Purpose

Generally, the purpose of an exam for treatment is to provide a diagnosis and appropriate treatment for the person you examine. On the other hand, a C&P disability exam has the purpose of providing diagnostic and other clinical evidence concerning the severity of a disability needed by VBA to determine entitlement to benefits for the person you examine.

Audience

The findings you report from a treatment exam will be read primarily by health care providers. By comparison, the disability exam report is a legal document used in the process of adjudicating a Veteran's or Servicemember's claim for benefits. The audience for a disability exam report is primarily a Rating Veterans Service Representative (RVSR) or Decision Review Officer (DRO), but the audience could include attorneys and judges in a court of law as well as other C&P examiners.

Legal Medical Evidence for Adjudication

Generally speaking, the assessments that you perform and document will be requested by an RVSR within the VBA. The RVSR uses information from you, along with all other evidence of record, to adjudicate a benefits claim in accordance with the Schedule for Rating Disabilities, Part 4 of Title 38 of the Code of Federal Regulations, (38 CFR Part 4). The information requested from you, the disability examiner, will be based on adjudication needs and not on treatment considerations.

Note: The final exam report is primarily for legal purposes to be read and understood by adjudicators, lawyers, and judges.

A New Context for the Veteran or Servicemember

You will be working on behalf of the Veteran or Servicemember that you examine in a very structured way, according to legal needs. You are part of a mission to help a Veteran or Servicemember get a quick and accurate determination on a claim that he or she filed with VA.

As with any interaction with a Veteran or Servicemember, you want to be courteous and informative. However, you will want to remember your role as a disability examiner when you guide the Veteran or Servicemember through the examination, and when you answer questions that seem natural enough for him/her to ask. Best practices on how to prepare and guide the Veteran or Servicemember through a disability exam will be discussed in this course. There will be pointers to help you determine the most helpful responses to questions or requests from Veterans or Servicemembers who are more used to treatment exams.

Lesson Summary

This lesson focused on how the disability exam is different from the treatment exam. This lesson covered the legal nature of the information that a disability exam and report provide to VBA for adjudication of a Veteran's or Servicemember's claim for benefits. It should be clear that your role as a disability examiner benefits the Servicemember or Veteran by providing services as part of a quick and accurate response to his or her claim.

The next lesson will introduce you to important legal concepts and terms that influence the C&P exam.

C&P Process and Terminology

Learning Objectives

In this lesson, you will learn why disability exams are also referred to as C&P exams. Your role in the C&P process will be explained. Since your role starts with a Request for Examination, also known as VA Form 21-2507, the types of exams seen on the Request and legal terminology used on the Request will be explained. You will have an opportunity to apply what you learn by applying legal definitions to sample case scenarios.

This lesson is intended to help you master the following learning objectives:

- Describe the disability examiner's role in the C&P claims process
- Define exam priorities found on Request for Examination forms
- Define C&P legal terms used on Request for Examination forms

A sample Request for Examination form for Mr. John Doe is included in this lesson. Please note: All names used for Veterans or Servicemembers in this course are fictional and are not intended to resemble any Veterans or Servicemembers, or their actual situation.

Compensation and Pension Defined

Compensation and pension are two different categories of benefits paid by VA to Veterans based on conditions or disabilities.

Compensation

Compensation refers to monetary benefits that are paid to Veterans to compensate for average loss of earning potential due to service-connected (SC) conditions, meaning conditions which were incurred or aggravated in active military service.

Pension

Pension is a needs-based monetary benefit payable by VA for wartime Veterans who are permanently and totally disabled from nonservice-connected (NSC) conditions or a combination of SC and NSC conditions, none of which are the result of their own willful misconduct.

Select each linked term that follows for a detailed definition that pulls all of this information together in the course Glossary.

SC Disability Compensation
NSC Disability Pension

Where Do You Fit In?

VBA is responsible for a wide variety of benefit programs authorized by Congress, including researching and adjudicating Servicemember and Veteran claims for SC disability compensation and NSC disability pension.

The VBA will request C&P examinations from your office through a Veterans Service Center (VSC) associated with a VA Regional Office (VARO or RO).

Here is an overview of the claims process to help you understand what happens before and after you examine a Veteran or Servicemember and write up your report.

Where Do You Start?

If an RVSR reviews a substantially complete application for disability benefits and determines that the Veteran's or Servicemember's claim shows merit but lacks sufficient clinical evidence, the RVSR will transmit a Request for Examination to the appropriate facility.

The Request for Examination is the first document to review in detail before you conduct the requested C&P examination. The Request for Examination can include some or all of the following information and requests:

- The Veteran's or Servicemember's identifying information
- The examination priority
- The types of examination required
- Any currently rated disabilities
- General remarks, including the disability claimed by the Veteran or Servicemember
- Specific requests for pertinent evidence and questions that must be answered for the examination to be adequate for rating purposes
- Request for an opinion, such as a nexus opinion
- The name and phone number of the RVSR who requests the examination

This lesson will review just the first part of a sample Request for Examination form for Mr. Doe. Select Request for Examination to view or print the entire form before we begin.

Request for Examination

Request for Examination

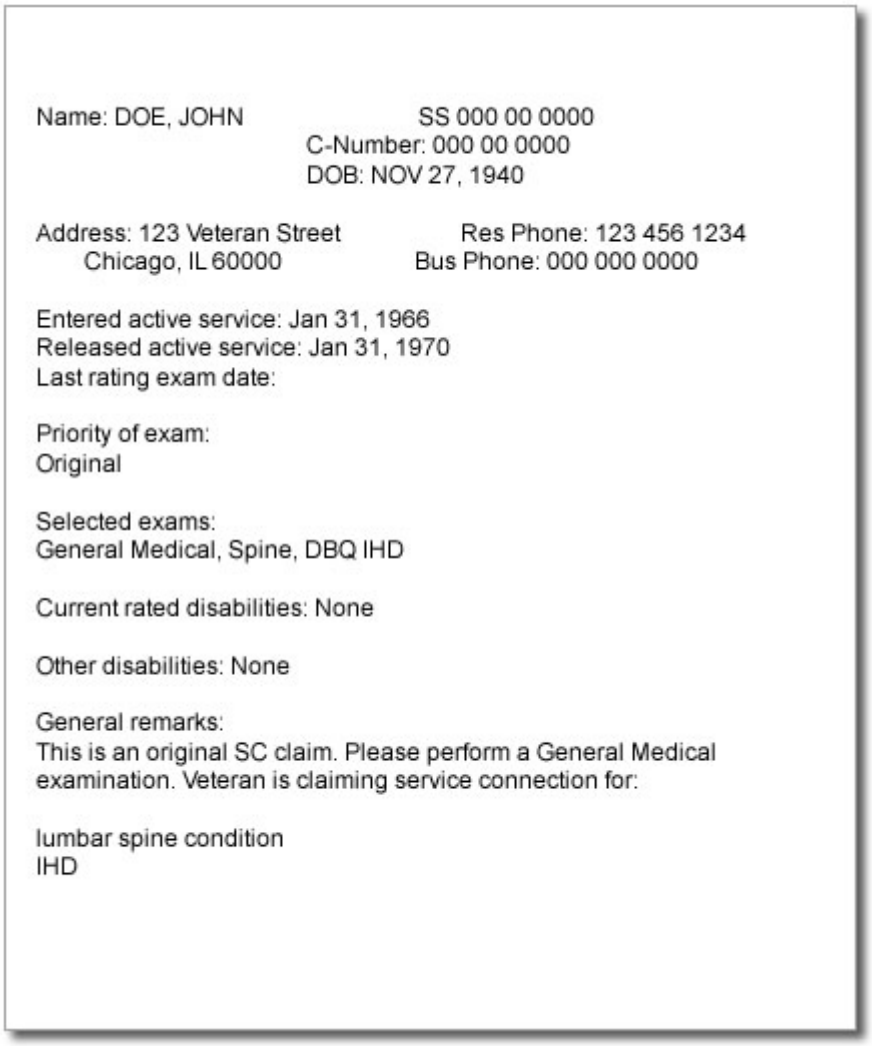
Let's start at the top of a sample Request for Examination form.

Mr. John Doe has filed a claim for benefits. You are given Mr. Doe's dates of active military service. The Priority of the exam is "Original." What does "Original" priority mean?

Also, under General remarks, the term, "original SC claim," is used, referring to Mr. Doe's claim as being his first claim for service connection (SC) for a condition that he believes was incurred or aggravated by active military service.

The types of exams requested in this sample Request for Examination are meant to illustrate what information is needed from the disability exam and the use of various types of examination protocols.

Important Note: For purposes of this training, a request for a General Medical exam is included on the Request for Examination. However, ordinarily a General Medical exam would only be requested under the following specific circumstances: if the Veteran makes an original claim for service connection within the designated time allowed (or designated timeframe, etc.) after discharge from service, if the Veteran is claiming individual unemployability due to service-connected conditions, or if the Veteran is claiming (NSC) pension.



Name: DOE, JOHN SS 000 00 0000
C-Number: 000 00 0000
DOB: NOV 27, 1940

Address: 123 Veteran Street Res Phone: 123 456 1234
Chicago, IL 60000 Bus Phone: 000 000 0000

Entered active service: Jan 31, 1966
Released active service: Jan 31, 1970
Last rating exam date:

Priority of exam:
Original

Selected exams:
General Medical, Spine, DBQ IHD

Current rated disabilities: None

Other disabilities: None

General remarks:
This is an original SC claim. Please perform a General Medical examination. Veteran is claiming service connection for:

lumbar spine condition
IHD

Disability Exam Priorities

The Request for Examination for Mr. Doe calls for an Original SC Exam. This is only one of several examination priorities that you might see on a Request for Examination. Select each of the eight exam priority types that follow to read a description of the priority. There is a Knowledge Check on the next page with questions based on exam priority descriptions given here.

Original SC Examination

An original exam to establish SC disability involves a Veteran or Servicemember who claims for the first time a condition or conditions that he or she believes is related to an injury, illness, or event that occurred during military service. When you conduct the examination, you should take a detailed history of the claimed condition or conditions from the date of onset until the present day, including any mechanism of injury.

Timeframe: Make sure you report any diagnosis, symptoms, functional limits, and/or treatment the Veteran or Servicemember received before, during, and after military service.

Original NSC Pension Examination

An NSC pension exam is an evaluation of a disability resulting from a disease or injury which was not incurred or aggravated in active military service. Additional specific VBA criteria must be met, such as active service during wartime.

Increase Examination

An Increase exam involves an evaluation of a disability that has already been determined as SC. The Veteran believes the claimed condition(s) has worsened since the last rating examination.

Timeframe: You should take a detailed history of the condition(s) identified in the examination request from the date of the last C&P examination until today.

Review Examination

A Review exam involves an evaluation of a disability that has already been determined as SC. But unlike an "increase" request, the VSC initiates a Review request to determine whether or not the current disability rating is still appropriate. (NOTE: For certain disabilities that are not static, VA is required to periodically re-evaluate their disabling effects on the Veteran.)

Timeframe: When you conduct the examination, you should take a detailed history of the claimed condition(s) from the date of the last C&P exam until today.

POW Examination

The POW exam is conducted to determine the baseline medical condition of the Veteran or Servicemember from his/her incarceration as a POW to this point in time. Approach these Veterans or Servicemembers with the greatest sensitivity because the POW experience likely resulted in a great deal of psychological and physical trauma. Each disability, disease, and condition the Veteran or Servicemember is claiming as a consequence of the POW experience needs to be detailed, and often the C&P examiner is the first person the Veteran or Servicemember discloses his/her experiences to. Details about beatings, torture, forced marches, forced labor, diet, disease, brainwashing, extremes of hot and cold, psychological abuse, and anxiety may be significant parts of the Veteran's or Servicemember's history. Eliciting these details requires that one establish a trusting relationship with the Veteran or Servicemember.

Terminal Examination

The Terminal exam is an expedited exam type requested for a Veteran or Servicemember in the final stages of a fatal disease, or approaching or close to death. Completion of the examination and report by VHA and adjudication by VBA is expected to be accomplished within days of receiving the Veteran's/Servicemember's claim.

Inadequate Examination

An Inadequate exam is requested when a prior exam report is deemed insufficient for adjudication purposes. Examples of an inadequate exam request include, but are not limited to, these oversights: the report is unsigned: the report does not address all disabilities for which an examination was requested; exam template, worksheet, or DBQ is not fully completed; or a medical opinion was requested but not provided; or a medical opinion was provided but it either does not include a supporting rationale or the rationale provided is incomplete or otherwise inadequate.

Other Examinations

Two examples of other examination priorities are Appeal and BVA Remand. A Veteran or Servicemember who is dissatisfied with his/her rating decision can appeal that decision to VBA, and if the Veteran is dissatisfied with the appeal decision, he or she can continue their appeal upward to the Board of Veterans' Appeals (BVA), the U.S. Court of Appeals for Veterans Claims (CAVC), the U.S. Court of Appeals for the Federal Circuit, and finally to the U.S. Supreme Court. An appeal or remand may result in the need for an additional examination, or there may be a remand, or a request from BVA for VHA to re-examine the Veteran/Servicemember. The examiner may be asked to answer specific questions as detailed in the request.

Disability Claim Terminology

Many legal terms influence what information an RVSR might ask for — or not ask for — on a Request for Examination. Indeed, the area of Veterans benefits is loaded with "legal terms of art," terms that either have meanings that are strictly defined by law or that have their own legal meanings. A basic understanding of a few of these terms will help the examiner provide the information necessary for the RVSR to adjudicate a given claim.

In the next few pages, you will be provided with the definitions of legal terms and concepts used in Request for Examination forms.

Direct Service Connection

Definition

For disability resulting from personal injury suffered or disease contracted in line of duty, in the active military, naval, or air service, compensation will be paid to any Veteran discharged or released under conditions other than dishonorable from the period of service in which such injury or disease was incurred. In other words, direct service connection is established if the Veteran's or Servicemember's current disability was caused by or resulted from his military service. When all of the evidence, including that pertinent to service, establishes that a condition was incurred in service, direct service connection can still be established even though there was no documented complaint or symptoms of the condition in service.

Presumption of Soundness

Read the definition and case study below.

Definition

The presumption of soundness means that, upon entering service, an individual will be presumed to be in sound condition except for defects, infirmities, or disorders "noted" at the time of entry into service. Important to this presumption is that only such conditions that are documented on the individual's

entrance examination are to be considered as "noted." The presumption of soundness may be rebutted by clear and unmistakable (obvious or manifest) evidence demonstrating that an injury or disease existed prior to service.

Adjudication Case Study

Mr. Jones is claiming service connection for degenerative joint disease of the right knee.
Dates of service: January 1990 to January 1991.
Evidence: At the time of the entrance examination, physical examination showed limited range of motion in the knee, and the examiner noted a history of a right knee strain.

1. Based on the evidence, is Mr. Jones entitled to presumption of soundness?

Aggravation

Definition

If the presumption of soundness does not apply and an individual had a disability that existed prior to service, then it must be determined whether the "pre-existing disability" was aggravated by service. Simply put, aggravation means that a pre-existing disability became permanently worse during service. However, a pre-existing disability that underwent an increase in severity in service will not be considered to be aggravated by service if it is determined that any increase resulted from the natural progression of the disease. Furthermore, temporary flare-ups of an injury or disease will not be considered a permanent increase in the severity of the condition.

Secondary Service Connection

Definition

Secondary service connection is when service connection is granted for a disability caused by an already service-connected disorder. Another type of secondary service connection is when aggravation of a Veteran's NSC disorder is proximately due to or the result of a service-connected disorder and not due to the natural progress of the NSC disorder. In these cases the examiner may be requested to identify the baseline and current level of severity of the NSC disorder.

Combat and Non-Combat Defined

Combat service is a legal finding of fact and requires the Veteran to have participated in events constituting an actual fight or encounter with a military foe or hostile unit or instrumentality.

In order to establish service connection, the Veteran or Servicemember must show there was an event or injury during service. Combat service has the result of relaxing evidentiary standards for determining what happened during service. In these cases, VA will accept as true a Veteran's allegation that an event, injury, or symptom occurred during combat service provided that the lay evidence is consistent with the circumstances, conditions, and hardships of service. The statements will be accepted as true without any further proof or credibility determination and even though there is no official record of the event, injury, or symptoms in the service treatment records. This relaxed standard applies only to what happened during combat.

For these cases, the examiner should elicit and accept as true the Veteran's reported history of how the injury began during combat service. The relevant question becomes whether it is more likely than not that the current claimed condition is related to that combat injury. If there is any question as to whether a Veteran served in combat, this is a factual matter that must be decided first by the VA claims adjudicator.

Combat and Non-Combat Study

Read the adjudication case study presented here and then answer both questions based on the evidence given for each. Select Submit for feedback on your answers.

Lay Evidence

What is Lay Evidence

Lay evidence is defined as any evidence or statements by a person without specialized education, training, or experience. In other words, this is a statement provided by someone who does not have a medical background or training. Generally, this evidence is provided by a person who has the knowledge of facts or circumstances and conveys matters that can be observed through the senses or via firsthand knowledge.

How is Lay Evidence Used?

For adjudication purposes, lay evidence can be used to provide evidence of an event, injury, or symptoms of a disease during service; and in some cases, evidence of a current disability, especially when it is capable of observation, e.g., varicose veins or flat feet. Lay evidence can also be used to describe the onset, severity, frequency, and length of time any findings have persisted, e.g., limping of right leg and intermittent swelling of right ankle since service.

When to Consider Lay Evidence

Whether or not the lay statements are credible is a legal determination made on a fact-specific basis. There may be times when the RVSR or BVA specifically directs the examiner to consider a specific assertion to be credible and an opinion should be based with this in mind.

These statements generally appear in the "Subjective" or "Reported history" sections of medical evaluations. Regardless of whether any specific direction concerning credibility is provided, the examiner must consider and note these statements when providing a clinical opinion.

Lesson Summary

This lesson covered the basic claims process, exam priorities, and terminology that is used on or that influences the Request for Examination that starts your involvement in the claims process. You were provided definitions for C&P legal terms and given opportunities to explore how the terms are used.

More terms and information can be found in the course Glossary located in Resources.

Prepare for a C&P Examination

Learning Objectives

The time that is blocked for a disability exam includes time for you to prepare for the examination. This lesson will cover best practices for preparing for a disability exam. The focus will be on thoroughly reviewing the documentation provided to you before the examination begins. This lesson is designed to help you achieve the following objectives:

- Identify the information needed from a disability examination after reviewing a Request for Examination form and the DBQ(s) or other documentation protocols listed on the Request
- List the correct protocols for handling and using Veterans' Claims files

This lesson will continue the review of Mr. Doe's sample Request for Examination form in segments. Go to Resources, to see a sample Request for Examination for Mr. John Doe.

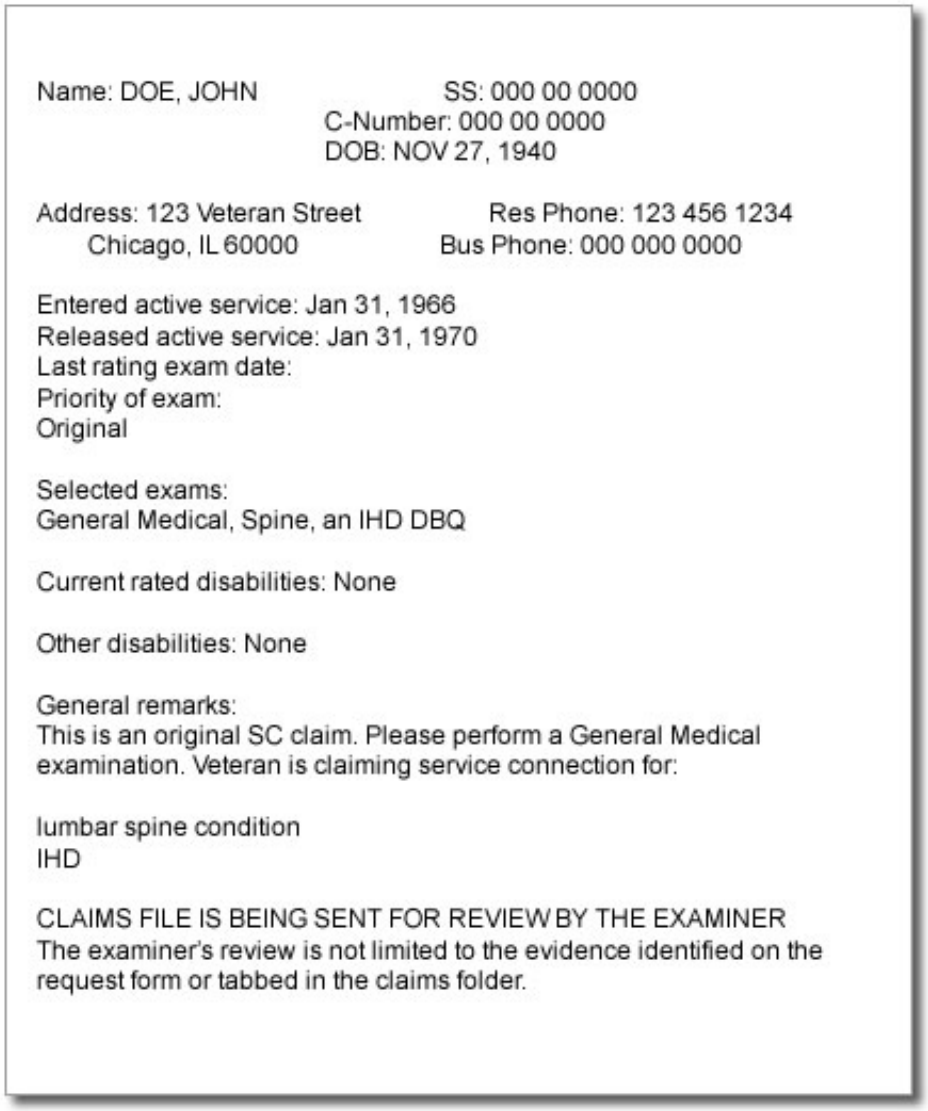
Documentation Protocols

As you recently learned, the Request for Examination form gives you details about whom you will examine and what information is needed from the disability exam. Let's see how you might use the information in Mr. Doe's Request for Examination to prepare for the exam.

First, notice that *Selected exams* listed on the form ON THE NEXT PAGE are General Medical, Spine, DBQ (Disability Benefits Questionnaire) for IHD (ischemic heart disease). The *Selected exams* section on the Request for Examination tells you which kind of exams to conduct, and at the same time, which Disability Benefits Questionnaires (DBQs), templates, or worksheets to access and use for the exam. Second, the Request tells you that the Claims File (C-file) is being sent for your review. Let's start with DBQs, templates, and worksheets, and then cover the C-file.

DBQs and Other Documentation Protocols

In general, you may use C&P DBQs, electronic templates in VHA's Compensation and Pension Record Interchange computerized system (CAPRI), or worksheets to guide the disability exam as you gather and document information required for rating disabilities during a C&P examination. In this case, you are required to use the IHD DBQ, as noted in the Request for Examination. For the other exams, you may use either a worksheet or an electronic template. When you document a DBQ, template, or worksheet as instructed, or complete an exam report, you provide evidence used to adjudicate the Veteran's or Servicemember's claim. Remember, the RVSR or other VBA requestor needs specific legal information required by the Schedule for Rating Disabilities, often referred to as the Rating Schedule.



Name: DOE, JOHN SS: 000 00 0000
C-Number: 000 00 0000
DOB: NOV 27, 1940

Address: 123 Veteran Street Res Phone: 123 456 1234
Chicago, IL 60000 Bus Phone: 000 000 0000

Entered active service: Jan 31, 1966
Released active service: Jan 31, 1970
Last rating exam date:
Priority of exam:
Original

Selected exams:
General Medical, Spine, an IHD DBQ

Current rated disabilities: None

Other disabilities: None

General remarks:
This is an original SC claim. Please perform a General Medical examination. Veteran is claiming service connection for:

lumbar spine condition
IHD

CLAIMS FILE IS BEING SENT FOR REVIEW BY THE EXAMINER
The examiner's review is not limited to the evidence identified on the request form or tabbed in the claims folder.

The Disability Benefits Questionnaire

The DBQ is a recent innovation intended to streamline the claims process for the claimant, the RVSR, and the disability examiner. The DBQ is designed to be a consistent and efficient means for guiding disability exams and for standardizing documentation, testing, and reporting. DBQs are expected to replace exam worksheets and templates over time. While currently DBQs are accessed both as electronic and printed forms, the ideal will be for disability examiners to access and document electronic DBQ templates in the Compensation and Pension Records Interchange (CAPRI) system on a computer.

DEMO periodically releases and updates DBQs. DBQs that have been released for use so far can be viewed online at the DEMO website or the Department of Veterans Affairs website. Select Resources at the bottom of this page to access DBQs online.

You'll continue your review of documents that will be used for Mr. Doe's exam on the next page.

Review the Worksheets and DBQ

Before you are finished with the Request for Examination, take a look at the General Medical and Spine worksheets and the Ischemic Heart Disease (IHD) DBQ that the Request lists. These documents are presented beginning on the following page.

General Medical Examination

Name:	SSN:
Date of Exam:	C-number:
Place of Exam:	

Narrative: This is a comprehensive base-line or screening examination for all body systems, not just specific conditions claimed by the veteran. It is often the initial post-discharge examination of a veteran requested by the Compensation and Pension Service for disability compensation purposes. As a screening examination, it is not meant to elicit the detailed information about specific conditions that is necessary for rating purposes. **Therefore, all claimed conditions, and any found or suspected conditions that were not claimed, should be addressed by referring to and following all appropriate worksheets, in addition to this one, to assure that the examination for each condition provides information adequate for rating purposes**. This does not require that a medical specialist conduct examinations based on other worksheets, except in the case of vision and hearing problems, mental disorders, or especially complex or unusual problems. **Vision, hearing, and mental disorder examinations must be conducted by a specialist**.

The examiner may request any additional studies or examinations needed for proper diagnosis and evaluation (see other worksheets for guidance). All important negatives should be reported. The regional office may also request a general medical examination as evidence for nonservice-connected disability pension claims or for claimed entitlement to individual unemployability benefits in service-connected disability compensation claims. Barring unusual problems, examinations for pension should generally be adequate if only this general worksheet is followed.

A. Review of Medical Records: Indicate whether the C-file was reviewed.

B. Medical History (Subjective Complaints):

1. Discuss: Whether an injury or disease that is found occurred during active service, before active service, or after active service. To the extent possible, describe the circumstances, dates, specific injury or disease that occurred, treatment, follow-up, and residuals. If the injury or disease occurred before active service, describe any worsening of residuals due to being in military service. Describe current symptoms,
2. If there are flareups of any joint (including of spine, hands, and feet) or muscle disease, state the frequency, duration, precipitating factors, alleviating factors, and the extent, if any, per veteran, they result in additional limitation of motion or other functional impairment during the flareup.
3. Describe details of current treatment, conditions being treated, and side effects of treatment.

4. Describe all surgery and hospitalizations in and after service with approximate

dates.

5. If a neoplasm is or was present, state whether benign or malignant and provide:
   a. Exact diagnosis and date of confirmed diagnosis.
   b. Location of neoplasm
   c. Types and dates of treatment
   d. For malignant neoplasm, also state exact date of the last surgical, X-ray, antineoplastic chemotherapy, radiation, or other therapeutic procedure.
   e. If treatment is already completed, provide date of last treatment and fully describe residuals. If not completed, state expected date of completion.

C. Physical Examination (Objective Findings):

Address each of the following and fully describe current findings: The examiner should incorporate results of all ancillary studies into the final diagnoses.

1. **VS:** Heart rate, blood pressure (see #13 below), respirations, height, weight, maximum weight in past year, weight change in past year, body build, and state of nutrition.

2. **Dominant hand:** Indicate the dominant hand and how this was determined, e.g., writes, eats, combs hair with that hand.

3. **Posture and gait:** Describe abnormality and reason for it. Describe any ambulatory aids and name the condition requiring the ambulatory aid(s).

4. **Skin, including appendages:** If abnormal, describe appearance, location, extent of lesions. If there are laceration or burn scars, describe the location, exact measurements (cm. x cm.), shape, depression, type of tissue loss, adherence, and tenderness. See the Scars worksheet for further guidance. Describe any limitation of activity or limitation of motion due to scarring or other skin lesions. **NOTE:** If there are disfiguring scars (of face, head, or neck), obtain color photographs of the affected area(s) to submit with the examination report.

5. **Hemic and Lymphatic:** Describe adenopathy, tenderness, suppuration, edema, pallor, etc.

6. **Head and face:** Describe scars, skin lesions, deformities, etc., as discussed under Skin.

7. **Eyes:** Describe external eye, pupil reaction, eye movements. State corrected visual acuity and gross visual field assessment.

8. **Ears:** Describe canals, drums, perforations, discharge. State whether hearing is grossly normal or abnormal. Is there a current complaint of tinnitus? If so, do you believe it is related to a current medical or psychological

problem, or is the etiology unknown without further information?

9. **Nose, sinuses, mouth and throat:** Include gross dental findings. For sinusitis, describe headaches, pain, incapacitating (meaning an episode of sinusitis that requires bed rest and treatment by a physician with 4-6 weeks of antibiotic treatment), and non-incapacitating episodes of sinusitis during the past 12-month period frequency and duration of antibiotic treatment.

10. **Neck:** Describe lymph nodes, thyroid, etc.

11. **Chest:** Inspection, palpation, percussion, auscultation. Describe respiratory symptoms and effect on daily activities, e.g., how far the veteran can walk, how many flights of stairs veterans can climb. If a respiratory condition is claimed or suspected, refer to appropriate worksheet(s). Most respiratory conditions will require PFT's, including post-bronchodilation studies.

12. **Breast:** Describe masses, scars, nipple discharge, skin abnormalities. Give date of last mammogram, if any. Describe any breast surgery (with approximate date) and residuals.

13. **Cardiovascular:** NOTE: If there is evidence of a cardiovascular disease, or one is claimed, refer to appropriate worksheet(s).

    a. Record pulse, quality of heart sounds, abnormal heart sounds, arrhythmias. Describe symptoms and treatment for any cardiovascular condition, including peripheral arterial and venous disease. Give NYHA classification of heart disease. A determination of METs by exercise testing may be required for certain cardiovascular conditions, and an estimation of METS may be required if exercise testing cannot be conducted for medical reasons. Report heart size and how determined. (See the cardiovascular worksheets for further guidance.)
    b. Describe the status of peripheral vessels and pulses. Describe edema, stasis pigmentation or eczema, ulcers, or other skin or nail abnormalities. Describe varicose veins, including extent to which any resulting edema is relieved by elevation of extremity. Examine for evidence of residuals of cold injury when indicated. See and follow special cold injury examination worksheet if there is a history of cold exposure in service and the special cold injury examination has not been previously done.
    c. **Blood Pressure:** (Per the rating schedule, hypertension means that the diastolic blood pressure is predominantly 90mm. or greater, and isolated systolic hypertension means that the systolic blood pressure is predominantly 160mm. or greater with a diastolic blood pressure of less than 90mm.)

        i. If the diagnosis of hypertension has not been previously established, and it is a claimed issue, B.P. readings must be taken two or more times on each of at least three different days.
        ii. If hypertension has been previously diagnosed and is claimed, but the

claimant is not on treatment, B.P. readings must be taken two or more times on at least three different days.

iii. If hypertension has been previously diagnosed, and the claimant is on treatment, take three blood pressure readings on the day of the examination.

iv. If hypertension has not been claimed, take three blood pressure readings on the day of the examination. If they are suggestive of hypertension or are borderline, readings must be taken two or more times on at least two additional days to rule hypertension in or out.

v. In the diagnostic summary, state whether hypertension is ruled in or out after completing these B.P. measurements. If hypertensive heart disease is suspected or found, follow worksheet for Heart.

14. **Abdomen:** Inspection, auscultation, palpation, percussion. Describe any organ enlargement, ventral hernia, mass, tenderness, etc.

15. **Genital/rectal (male):** Inspection and palpation of penis, testicles, epididymis, and spermatic cord. If there is a hernia, describe type, location, size, whether complete, reducible, recurrent, supported by truss or belt, and whether or not operable. Describe anal fissures, hemorrhoids, ulcerations, etc. Include digital exam of rectal walls and prostate.

16. **Genital/rectal (female):** Pelvic exam, including inspection of introitus, vagina, and cervix, palpation of labia, vagina, cervix, uterus, adnexa, and ovaries, rectal exam. Do Pap smear if none within past year. If unable to conduct an examination and Pap smear, or if there is a severe or complex problem, refer to a specialist.

17. **Musculoskeletal:**

    a. For all joint or muscle disorders, state each muscle and joint affected.
    b. Separately examine and describe in detail each affected joint. Measure active range of motion in degrees using a goniometer. State whether there is objective evidence of pain on motion. After 3 repetitions of the range of motion, state whether there are additional limitations of range of motion and whether there is objective evidence of pain on motion. Also state the most important factor (pain, weakness, fatigue, lack of endurance, incoordination) for any additional loss of motion after repetitive motion. Report the range of motion after 3 repetitions. (See the appropriate musculoskeletal worksheet for more details.)
    c. Describe swelling, effusion, tenderness, muscle spasm, joint laxity, muscle atrophy, fibrous or bony residual of fracture. If joint is ankylosed, describe the position and angle of fixation.
    d. If foot problems exist, also describe objective evidence of pain at rest and on manipulation, rigidity, spasm, circulatory disturbance, swelling, callus, loss of strength, and whether condition is acquired or congenital.
    e. If there is amputation of a part, see the appropriate worksheet.

f. With disc disease, also describe any abnormal neurological findings and total duration in days or weeks of incapacitating episodes (an incapacitating episode is a period of acute signs and symptoms due to intervertebral disc syndrome that requires bed rest prescribed by a physician and treatment by a physician).

18. **Endocrine:** Describe signs and symptoms of any endocrine disease, effects on other body systems. See endocrine worksheets for further guidance.

19. **Neurological:** Assess orientation and memory, gait, stance, and coordination, cranial nerve functions. Assess deep tendon reflexes, pain, touch, temperature, vibration, and position, motor and sensory status of peripheral nerves. If neurological abnormalities are found on examination, or there is a history of seizures, refer to appropriate worksheet.

20. **Psychiatric:** Describe affect, mood, judgment, behavior, comprehension of commands, hallucinations or delusions, and intelligence (This is meant to be a brief screening examination. If a mental disorder is claimed, or suspected based on the screening, an examination for diagnosis and assessment should be conducted by a psychiatrist or psychologist.)

D. Diagnostic and Clinical Tests:

1. Include results of all diagnostic and clinical tests conducted in the examination report.
2. Review all test results before providing the summary and diagnosis.
3. Follow additional worksheets, as appropriate.
4. The diagnosis of degenerative or traumatic arthritis of any joint requires X-ray confirmation, but once confirmed by X-ray, either in service or after service, no further X-rays of that joint are required for disability evaluation purposes.

E. Diagnosis:

1. Provide a summary list of all disabilities diagnosed. Include an interpretation of the results of all diagnostic and other tests conducted in the final summary and diagnosis.

2. For each condition diagnosed, describe its effect on the veteran's usual occupation and daily activities.
3. **Capacity to Manage Financial Affairs:** Mental competency, for VA benefits purposes, refers only to the ability of the veteran to manage VA benefit payments in his or her own best interest, and not to any other subject. Mental incompetency, for VA benefits purposes, means that the veteran, because of injury or disease, is not capable of managing benefit payments in his or her best interest. In order to assist raters in making a legal determination as to competency, please address the following:

What is the impact of injury or disease on the veteran's ability to manage his or her financial affairs, including consideration of such things as knowing the amount of his or her VA benefit payment, knowing the amounts and types of bills owed monthly, and handling the payment prudently? Does the veteran handle the money and pay the bills himself or herself?

Based on your examination, do you believe that the veteran is capable of managing his or her financial affairs? Please provide examples to support your conclusion.

If you believe a Social Work Service assessment is needed before you can give your opinion on the veteran's ability to manage his or her financial affairs, please explain why.

Signature: Date:

Spine Examination

Name: SSN:

Date of Exam: C-number:

Place of Exam:

A. Review of Medical Records:

B. Present Medical History (Subjective Complaints):

Please comment on whether the etiology for any of these subjective complaints is unrelated to the claimed disability.

1. Provide date, circumstances of onset and course since onset.
2. Report complaints of pain (including any radiation)
    a. Onset, description of pain
    b. Location and distribution
    c. Duration, frequency
    d. Severity (mild, moderate, severe)
    e. Have there been incapacitating episodes of back pain in the past 12 months? Duration? (Incapacitating episodes are episodes that require bedrest prescribed by a physician and treatment by a physician.)
3. Describe treatment - type, include dose for medication, frequency, response, and side effects.
4. Provide the following (per veteran) if individual reports periods of flare-up:
    a. Severity, frequency, and duration.
    b. Precipitating and alleviating factors.
    c. Additional limitation of motion or functional impairment during the flare-up.
5. Describe associated features or symptoms (e.g. stiffness, fatigue, spasms, weakness, decreased motion, numbness, paresthesias, leg or foot weakness, bladder complaints, (i.e. urinary incontinence (how treated, appliance, absorbent material, number of times changed per 24 hours), urgency, retention (require catheterization), frequency (daytime voiding interval, nocturia)), bowel complaints (i.e. obstipation, fecal incontinence (extent of leakage, pads?), erectile dysfunction).
6. Describe walking and assistive devices.

a. Does the veteran walk unaided? Does the veteran use a cane, crutches, or a walker?
b. Does the veteran use a brace (orthosis)?
c. How far and how long can the veteran walk?
d. Is the veteran unsteady? Does the veteran have a history of falls?

7. Describe details of any trauma or injury, including dates.
8. Describe details of any hospitalizations or surgery, include dates and locations if known.
9. Functional Assessment - Describe effects of the condition(s) on the veteran's mobility (e.g.,
walking, transfers), activities of daily living (i.e., eating, grooming, bathing, toileting, dressing),
usual occupation, driving.
10. History of neoplasm:
    a. Date of diagnosis, diagnosis.
    b. Benign or malignant.
    c. Type and date(s) of treatment.
    d. Date of last treatment.

C. Physical Examination (Objective Findings): Address each of the following as appropriate to the condition being examined and fully describe current findings:

1. Inspection: spine, limbs, posture and gait, position of the head, curvatures of the spine, symmetry in appearance.
2. Range of motion

a. **Cervical Spine**

The reproducibility of an individual's range of motion is one indicator of optimum effort. Pain, fear of injury, disuse or neuromuscular inhibition may limit mobility by decreasing the individual's effort. If range of motion measurements fail to match known pathology, please repeat the measurements. (Reference: Guides to the Evaluation of Permanent Impairment, Fifth Edition, 2001, page 399).

i. Using a goniometer, measure and report the range of motion in degrees of forward flexion, extension, left lateral flexion, right lateral flexion, left lateral rotation and right lateral rotation. Generally, the normal ranges of motion for the cervical spine are as follows:

- Forward flexion: 0 to 45 degrees
- Extension: 0 to 45 degrees
- Left Lateral Flexion: 0 to 45 degrees

- Right Lateral Flexion: 0 to 45 degrees
- Left Lateral Rotation: 0 to 80 degrees
- Right Lateral Rotation: 0 to 80 degrees

There may be a situation where an individual's range of motion is reduced, but "normal" (in the examiner's opinion) based on the individual's age, body habitus, neurologic disease, or other factors unrelated to the disability for which the exam is being performed. In this situation, please explain why the individual's measured range of motion should be considered as "normal".

ii. Describe presence or absence of objective evidence of pain.

iii. Describe objective evidence of painful motion, spasm, weakness, tenderness, atrophy, guarding, etc.

iv. Describe any postural abnormalities, fixed deformity (ankylosis), or abnormality of musculature of cervical spine musculature.

b. **Thoracolumbar spine**

The reproducibility of an individual's range of motion is one indicator of optimum effort. Pain, fear of injury, disuse or neuromuscular inhibition may limit mobility by decreasing the individual's effort. If range of motion measurements fail to match known pathology, please repeat the measurements. (Reference: Guides to the Evaluation of Permanent Impairment, Fifth Edition, 2001, page 399).

It is best to measure range of motion for the thoracolumbar spine from a standing position. Measuring the range of motion from a standing position (as opposed to from a sitting position) will include the effects of forces generated by the distance from the center of gravity from the axis of motion of the spine and will include the effect of contraction of the spinal muscles. Contraction of the spinal muscles imposes a significant compressive force during spine movements upon the lumbar discs.

i. Provide forward flexion of the thoracolumbar spine as a unit. Do not include hip flexion. (See Magee, Orthopedic Physical Assessment, Third Edition, 1997, W.B. Saunders Company, pages 374-75). Using a goniometer, measure and report the range of motion in degrees for forward flexion, extension, left lateral flexion, right lateral flexion, left lateral rotation and right lateral rotation. Generally, the normal ranges of motion for the thoracolumbar spine as a unit are as follows:

- Forward flexion: 0 to 90 degrees
- Extension: 0 to 30 degrees

- Left Lateral Flexion: 0 to 30 degrees
- Right Lateral Flexion: 0 to 30 degrees
- Left Lateral Rotation: 0 to 30 degrees
- Right Lateral Rotation: 0 to 30 degrees

There may be a situation where an individual's range of motion is reduced, but "normal" (in the examiner's opinion) based on the individual's age, body habitus, neurologic disease, or other factors unrelated to the disability for which the exam is being performed. In this situation, please explain why the individual's measured range of motion should be considered as "normal".

ii. Describe presence or absence of objective evidence of pain.

iii. Describe objective evidence of painful motion, spasm, weakness, tenderness, atrophy, guarding etc.

a. Indicate whether there is muscle spasm, guarding or localized tenderness with preserved spinal contour, and normal gait.

b. Indicate whether there is muscle spasm, or guarding severe enough to result in an abnormal gait, abnormal spinal contour such as scoliosis, reversed lordosis or abnormal kyphosis.

iv. Describe any postural abnormalities, fixed deformity (ankylosis), or abnormality of musculature of back.

c. **Ankylosis**

If ankylosis is present, is it unfavorable or favorable? Unfavorable ankylosis is a condition in which the entire cervical spine, the entire thoracolumbar spine, or the entire spine is fixed in flexion or extension, and the ankylosis results in one or more of the following: difficulty walking because of a limited line of vision; restricted opening of the mouth and chewing; breathing limited to diaphragmatic respiration; gastrointestinal symptoms due to pressure of the coastal margin on the abdomen; dyspnea or dysphagia; alantoaxial or cervical subluxation or dislocation; or neurologic symptoms due to nerve root stretching. Favorable ankylosis is fixation of a spinal segment in neutral position (zero degrees). Indicate the accompanying sign(s) and/or symptom(s).

3. Neurological examination

Please perform complete neurologic evaluation as indicated based upon disability for which the exam is being performed. Please provide brief statement if any of the following (a-e) is not

included in exam. For additional neurologic effects of disability not captured by a - e, (e.g. bladder problems) please refer to appropriate worksheet for the body system affected.

a. Sensory examination, to include sacral segments (0 absent, 1 impaired, 2 normal).
b. Motor examination (atrophy, circumferential measurements, tone, and strength).

Standard muscle strength grading scale:

0 = Absent No muscle movement felt.

1 = Trace Muscle can be felt to tighten, but no movement produced.

2 = Poor Muscle movement produced only with gravity eliminated.

3 = Fair Muscle movement produced against gravity, but cannot overcome any resistance.

4 = Good Muscle movement produced against some resistance, but not against "normal resistance.

5 = Normal Muscle movement can overcome "normal" resistance.

c. Reflexes (deep tendon (0 absent, 1+ hypoactive, 2+ normal, 3+ hyperactive without clonus, 4+ hyperactive with clonus), cutaneous, and pathologic).
d. Rectal examination (sensation, tone, volitional control, and reflexes).
e. Lasegue's sign.

4. Non-organic physical signs (e.g., Waddell tests, others).

D. Functional Loss With Use:

Impairment of spine function is determined by range of motion as reported in the physical examination and additional loss of range of motion after repetitive use caused by the following factors:

1. Pain
2. Fatigue
3. Weakness
4. Lack of endurance
5. Incoordination

Have the veteran move the affected spinal segment through repetitive active range of motion, as tolerated (at least 3 repetitions). After repetitive motion re-measure the range of motion of the affected spinal segment. Do any of the above factors cause any additional loss of range of motion? If so, record the re-measured range of motion and state the predominant factor causing the change in motion.

If repetitive active range of motion cannot be done, state so and give the reason.

E. For intervertebral disc syndrome

1. Conduct and report a separate history and physical examination for each segment of the spine (cervical, thoracic, lumbar) affected by disc disease.
2. Conduct a complete history and physical examination of each affected segment of the spine (cervical, thoracic, lumbar), whether or not there has been surgery, as described above under B. Present Medical History and C. Physical Examination.
3. Conduct a thorough neurologic history and examination, as described in C5, of all areas innervated by each affected spinal segment. Specify the peripheral nerve(s) affected. Include an evaluation of effects, if any, on bowel or bladder functioning.
4. Describe as precisely as possible, in number of days, the duration of each incapacitating episode during the past 12-month period. An incapacitating episode, for disability evaluation purposes, is a period of acute signs and symptoms due to intervertebral disc syndrome that requires bed rest prescribed by a physician and treatment by a physician.

F. Diagnostic and Clinical Tests:

1. Imaging studies, when indicated.
2. For vertebral fractures, report the percentage of loss of height, if any, of the vertebral body.
3. Electrodiagnostic tests, when indicated.
4. Clinical laboratory tests, when indicated.
5. Isotope scans, when indicated.
6. Include results of all diagnostic and clinical tests conducted in the examination report.

G. Diagnosis:

Signature: Date:

Version: 4-20-2009

OMB Approved No. 2900-0749
Respondent Burden: 15 minutes

Department of Veterans Affairs

ISCHEMIC HEART DISEASE (IHD) DISABILITY BENEFITS QUESTIONNAIRE

IMPORTANT - THE DEPARTMENT OF VETERANS AFFAIRS (VA) ***WILL NOT PAY*** OR ***REIMBURSE*** ANY EXPENSES OR COST INCURRED IN THE PROCESS OF COMPLETING AND/OR SUBMITTING THIS FORM. PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN INFORMATION ON REVERSE BEFORE COMPLETING FORM.

NAME OF PATIENT/VETERAN	PATIENT/VETERAN'S SOCIAL SECURITY NUMBER

NOTE TO PHYSICIAN - Your patient is applying to the U.S. Department of Veterans Affairs (VA) for disability benefits. VA will use the information you provide on this questionnaire to process the Veteran's claim.

SECTION I - DIAGNOSIS

Note: IHD includes, but is not limited to, acute, sub-acute and old myocardial infarction; atherosclerotic cardiovascular disease including coronary artery disease (including coronary spasm) and coronary bypass surgery; and stable, unstable and Prinzmetal's angina. IHD does not include hypertension or peripheral manifestations of arteriosclerosis such as peripheral vascular disease or stroke, or any other condition that does not qualify within the generally accepted medical definition of ischemic heart disease.
IHD encompasses any atherosclerotic heart disease resulting in clinically significant ischemia or requiring coronary revascularization.

1A. DOES THE VETERAN HAVE ISCHEMIC HEART DISEASE *(IHD)*?
☐ YES ☐ NO

Note: Provide only diagnoses that pertain to IHD

1B. DIAGNOSIS # 1 -	ICD CODE -	DATE OF DIAGNOSIS -
1C. DIAGNOSIS # 2 -	ICD CODE -	DATE OF DIAGNOSIS -
1D. DIAGNOSIS # 3 -	ICD CODE -	DATE OF DIAGNOSIS -

1E. IF ADDITIONAL DIAGNOSES THAT PERTAIN TO IHD, LIST USING ABOVE FORMAT

SECTION II - MEDICAL HISTORY

2A. DOES THE VETERAN'S TREATMENT PLAN INCLUDE TAKING CONTINUOUS MEDICATION FOR THE DIAGNOSED CONDITION?
☐ YES ☐ NO

2B. LIST MEDICATIONS PRESCRIBED FOR IHD-RELATED CONDITIONS:

2C. IS THERE A HISTORY OF: *(Check all that apply and provide treatment facility and treatment date)*

CONDITION	YES *(Check)*	NO *(Check)*	TREATMENT FACILITY	DATE OF TREATMENT
PERCUTANEOUS CORONARY INTERVENTION (PCI)				
MYOCARDIAL INFARCTION				
CORONARY BYPASS SURGERY				
HEART TRANSPLANT *(If "Yes," is it as likely as not that the veteran's heart transplant is due to IHD?* ☐ YES ☐ NO)				
IMPLANTED CARDIAC PACEMAKER *(If "Yes," is it as likely as not that the veteran's pacemaker is due to IHD?* ☐ YES ☐ NO)				
IMPLANTED AUTOMATIC IMPLANTABLE CARDIOVERTER DEFIBRILLATOR (AICD) *(If "Yes," is it as likely as not that the veteran's AICD is due to IHD?* ☐ YES ☐ NO)				

SECTION III - CONGESTIVE HEART FAILURE (CHF)

3A. DOES THE VETERAN HAVE CHF? ☐ YES ☐ NO

3B. IS THE VETERAN'S CHF CHRONIC? ☐ YES ☐ NO

3C. IF THE VETERAN'S CHF IS NOT CHRONIC, HAS THE VETERAN HAD MORE THAN ONE EPISODE OF ACUTE CHF IN THE PAST YEAR? ☐ YES ☐ NO

If "Yes," provide name of treatment facility: _____

Date of most recent episode of CHF: _____

SECTION IV - CARDIAC FUNCTIONAL ASSESSMENT

4A. HAS A DIAGNOSTIC EXERCISE TEST BEEN CONDUCTED? ☐ YES ☐ NO

If "Yes," provide level of METS the veteran can perform as shown by diagnostic exercise testing: _____

Date of most recent test: _____

4B. IF EXERCISE METs TESTING WAS NOT COMPLETED BECAUSE IT IS NOT REQUIRED AS PART OF THE VETERAN'S TREATMENT PLAN, COMPLETE THE FOLLOWING METs TEST BASED ON THE VETERAN'S RESPONSES:

Lowest level of activity at which veteran reports symptoms *(Check all symptoms that apply)*

☐ DYSPNEA ☐ FATIGUE ☐ ANGINA ☐ DIZZINESS ☐ SYNCOPE

This METs Level has been found to be consistent with activities such as:

☐ **1-3 METs** *(This METs level has been found to be consistent with activities such as eating, dressing, taking a shower, slow walking (2 mph) for 1-2 blocks)*

☐ **>3-5 METs** *(This METs level has been found to be consistent with activities such as light yard work (weeding), mowing lawn (power mower), brisk walking (4 mph)*

☐ **>5-7 METs** *(This METs level has been found to be consistent with activities such as golfing (without cart), mowing lawn (push mower), heavy yard work (digging)*

☐ **>7-10 METs** *(This METs level has been found to be consistent with activities such climbing stairs quickly, moderate bicycling, sawing wood, jogging (6 mph)*

☐ Veteran denies experiencing above symptoms with any level of physical activity

SECTION V - DIAGNOSTIC TESTING

NOTE: Determination of cardiac hypertrophy/dilatation is required; the suggested order of testing for cardiac hypertrophy/dilatation is EKG, then chest x-ray (PA and lateral), then echocardiogram. Echocardiogram is only necessary if the other two tests are negative. A limited echocardiogram, if available, is appropriate to determine if cardiac hypertrophy/dilatation is present by measuring only left ventricular dimension, wall thickness and ejection fraction.

5A. IS THERE EVIDENCE OF CARDIAC HYPERTROPHY OR DILATATION?

☐ YES ☐ NO

5B. DIAGNOSTIC TEST AND DATE GIVEN *(Provide most recent test only)*

☐ EKG - Date of EKG: _____

☐ CHEST X-RAY - Date of chest x-ray: _____

☐ ECHOCARDIOGRAM - Date of echocardiogram: _____

☐ OTHER STUDY *(Specify)*: _____ (Date): _____

5C. LEFT VENTRICULAR EJECTION FRACTION (LVEF), IF KNOWN: _____ % DATE OF TEST: _____

(If LVEF testing is not of record, but available medical information sufficiently reflects the severity of the veteran's cardiovascular condition, LVEF testing is not required)

SECTION VI - FUNCTIONAL IMPACT AND REMARKS

6. DOES THE VETERAN'S IHD IMPACT THE VETERAN'S ABILITY TO WORK?

☐ YES ☐ NO *(If "Yes," describe impact, providing one or more examples)*

7. REMARKS *(If any)*

SECTION VII - PHYSICIAN'S CERTIFICATION AND SIGNATURE

CERTIFICATION - To the best of my knowledge, the information contained herein is accurate, complete and current.

8A. PHYSICIAN'S SIGNATURE	8B. PHYSICIAN'S PRINTED NAME	8C. DATE SIGNED

8D. PHYSICIAN'S PHONE NUMBER	8E. PHYSICIAN'S MEDICAL LICENSE NUMBER	8F. PHYSICIAN'S ADDRESS

NOTE - VA may obtain additional medical information, including an examination, if necessary to complete VA's review of the veteran's application.

IMPORTANT - Physician please fax the completed form to _____
(VA Regional Office FAX No.)

NOTE - A list of VA Regional Office FAX Numbers can be found at www.vba.va.gov/disabilityexams or obtained by calling 1-800-827-1000.

PRIVACY ACT NOTICE: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58/VA21/22/28, Compensation, Pension, Education and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is required to obtain or retain benefits. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by a Federal Statute of law in effect prior to January 1, 1975, and still in effect. The requested information is considered relevant and necessary to determine maximum benefits under the law. The responses you submit are considered confidential (38 U.S.C. 5701). Information submitted is subject to verification through computer matching programs with other agencies.

RESPONDENT BURDEN: We need this information to determine entitlement to benefits (38 U.S.C. 501). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 15 minutes to review the instructions, find the information, and complete the form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

On the job, you will access and complete electronic documentation or dictate examination reports if you are using worksheets. The method of access will depend on your facility. DBQs, worksheets, and templates will be updated occasionally, so they may look different than the examples for this course. As a disability examiner, you will have access to current versions.

General Medical Exam

In Mr. Doe's instance, the RVSR is requesting a General Medical Exam using the General Medical worksheet. The General Medical Exam is meant to be comprehensive, rather than focused on one or more conditions.

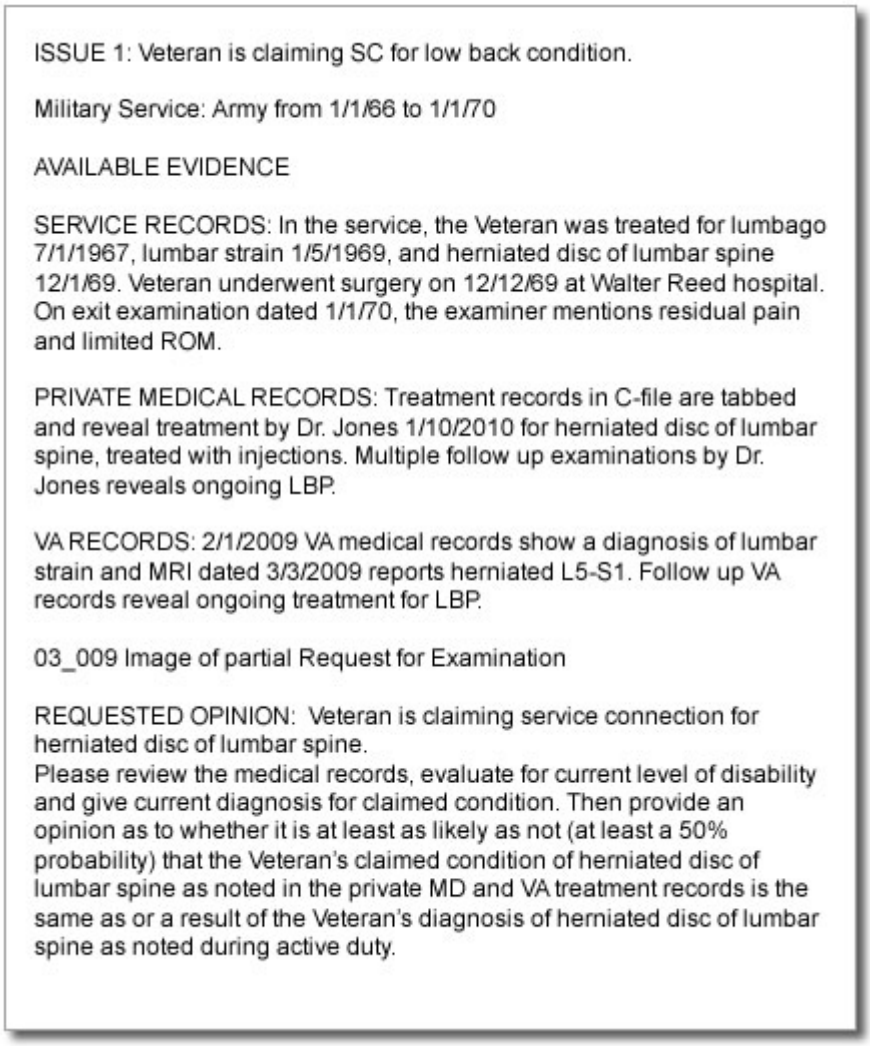
All claimed conditions and any found or suspected conditions that were not claimed should be addressed by referring to and following all appropriate worksheets, templates, or DBQs in addition to the General Medical Worksheet. This will assure that the examination for each condition provides information adequate for rating purposes.

Note: Depending on your discipline, you may not complete all requested examinations. A vision exam or mental disorder exam, if requested, would be performed by appropriate specialists.

Issue 1 on the Request for Examination

According to the Request for Examination, the first issue on this Request for Examination is a claim for a SC low back condition.

In addition to the DBQ, worksheets, or templates to review, there are Mr. Doe's service records and his VA clinical records to go over. There are also private clinical records for you to review in Mr. Doe's Claims File, or C-file.



ISSUE 1: Veteran is claiming SC for low back condition.

Military Service: Army from 1/1/66 to 1/1/70

AVAILABLE EVIDENCE

SERVICE RECORDS: In the service, the Veteran was treated for lumbago 7/1/1967, lumbar strain 1/5/1969, and herniated disc of lumbar spine 12/1/69. Veteran underwent surgery on 12/12/69 at Walter Reed hospital. On exit examination dated 1/1/70, the examiner mentions residual pain and limited ROM.

PRIVATE MEDICAL RECORDS: Treatment records in C-file are tabbed and reveal treatment by Dr. Jones 1/10/2010 for herniated disc of lumbar spine, treated with injections. Multiple follow up examinations by Dr. Jones reveals ongoing LBP.

VA RECORDS: 2/1/2009 VA medical records show a diagnosis of lumbar strain and MRI dated 3/3/2009 reports herniated L5-S1. Follow up VA records reveal ongoing treatment for LBP.

03_009 Image of partial Request for Examination

REQUESTED OPINION: Veteran is claiming service connection for herniated disc of lumbar spine.
Please review the medical records, evaluate for current level of disability and give current diagnosis for claimed condition. Then provide an opinion as to whether it is at least as likely as not (at least a 50% probability) that the Veteran's claimed condition of herniated disc of lumbar spine as noted in the private MD and VA treatment records is the same as or a result of the Veteran's diagnosis of herniated disc of lumbar spine as noted during active duty.

Veteran's Claims File (C-file)

The Veteran's Claims File, also known as the C-file, may be sent with a Request for Examination if the file contains pertinent information for the disability exam.

Like most C-files, Mr. Doe's file contains his private and sensitive information:

- Military service history
- Entrance examination and physical examination report
- Treatments during military service
- Exit examinations and physical examination report
- Private medical information the Veteran submitted to the Regional Office

You may recall that Mr. Doe's Examination Request remarked that private medical records were marked with tabs to ensure that you find them and look at them. The C-file will be helpful to you. But please note that your review is not limited to the evidence identified on the Request for Examination or in the C-file.

Generally speaking, a C-file can include more documents than the ones contained in Mr. Doe's C-file.

C-file Protocols

The C-file is a legal document requiring special handling on your part, under penalty of law:

- Keep the C-file safely secured when it is in your possession.
- Never add to or remove any information inside a C-file.
- Do not write in the margins - or anywhere in a C-file.
- Do not allow a Veteran or Servicemember to handle or read a C-file.

The C-file is the only record of Mr. Doe's claim, so please take care of it. When you finish with the C-file, take appropriate steps as required by your facility to ensure that the file is secured and will be sent back to VBA.

Note: If Mr. Doe wants to read his C-file; he must do so in the presence of an authorized VBA representative who gives permission for Mr. Doe to access the file. The same protocol applies for any person advocating for Mr. Doe.

Your Opinion Is Requested

The Request for Examination for Mr. Doe asks for an opinion for Issue 1, the SC low back condition. This is an example of when you should provide a medical opinion. Only give a medical opinion when you are

requested to do so. To do otherwise may complicate matters for VBA and for the Veteran or Servicemember you examine.

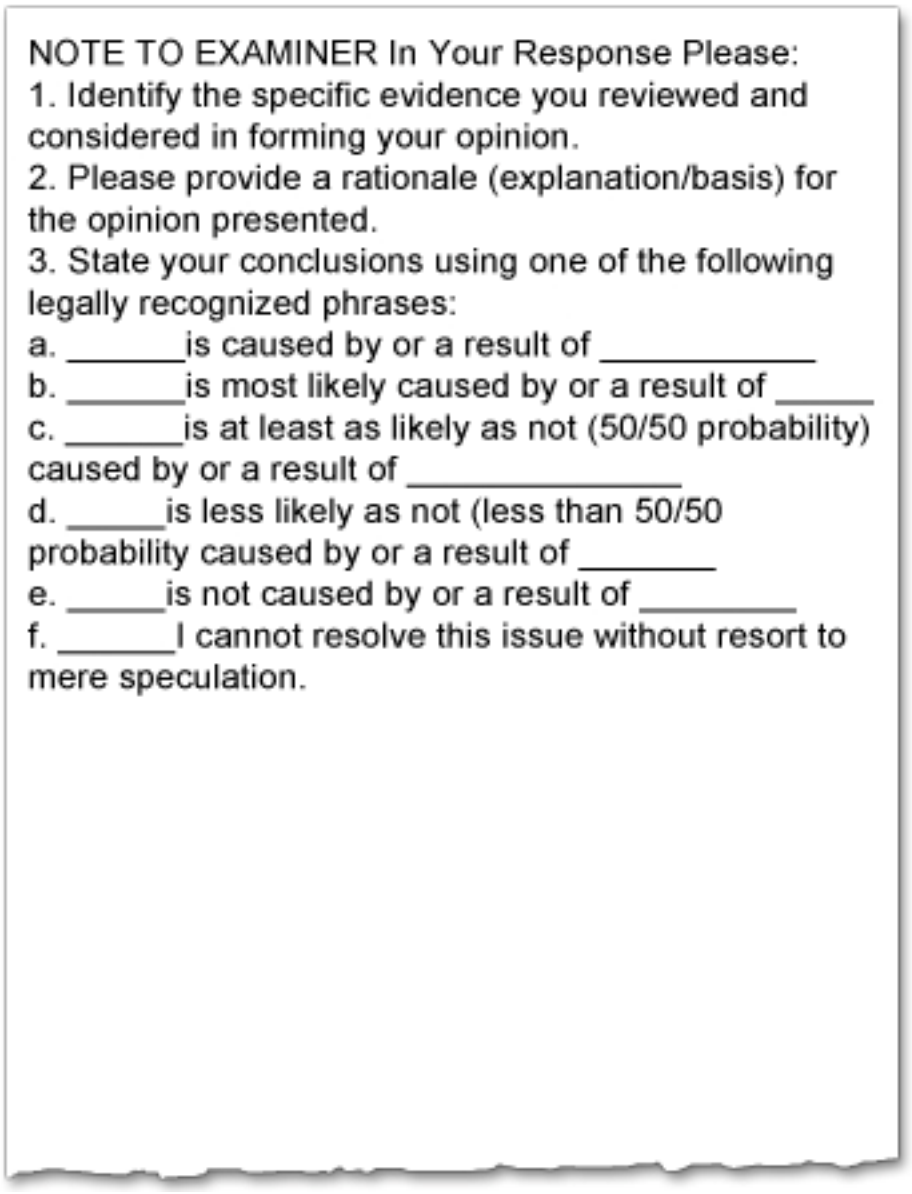
REQUESTED OPINION: Veteran is claiming service connection for herniated disc of lumbar spine. Please review the medical records, evaluate for current level of disability and give current diagnosis for claimed condition. Then provide an opinion as to whether it is at least as likely as not (at least a 50% probability) that the Veteran's claimed condition of herniated disc of lumbar spine as noted in the private MD and VA treatment records is the same as or a result of the Veteran's diagnosis of herniated disc of lumbar spine as noted during active duty.

Only give a medical opinion when requested to do so.

Documentation Protocols

For Mr. Doe's Request for Examination, you are requested to follow steps 1 through 3 on the Request for Examination. In order to provide an opinion, you are asked to review all medical records provided and perform an exam using the Spinal exam worksheet. Moreover, you are required to cite the evidence for your opinion and to give the rationale for your opinion. This is especially true for option f. in the Request for Examination pictured here, above where an opinion is not given. These are best practices for providing an opinion.

Note: Always cite the evidence and give the rationale for any opinion you provide, or your exam report will be considered insufficient for VBA's needs.

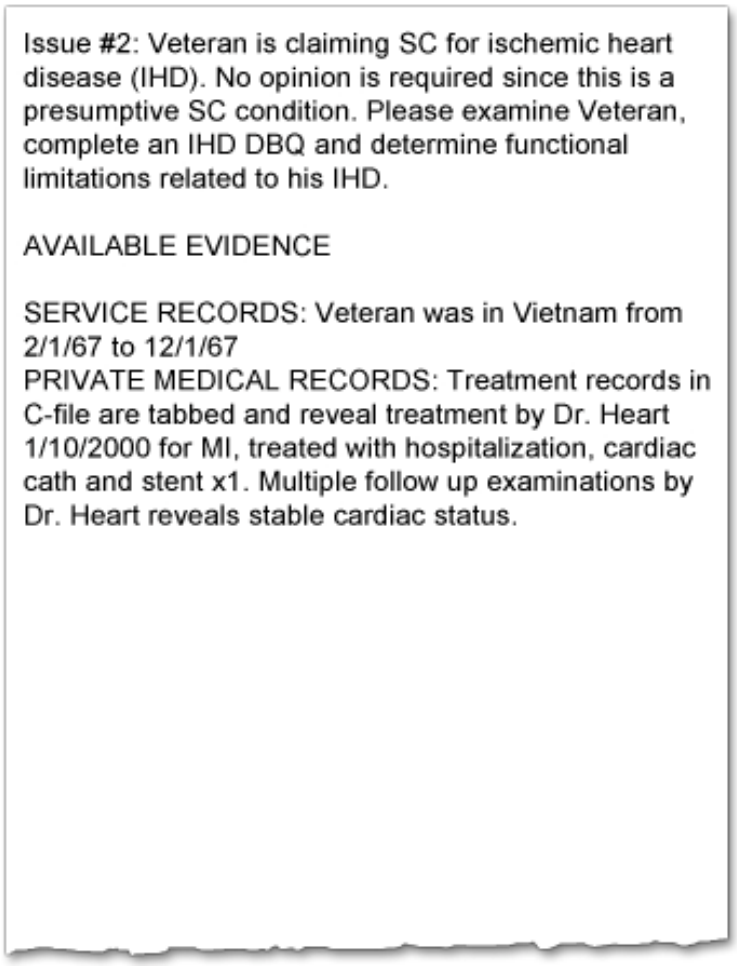

NOTE TO EXAMINER In Your Response Please:
1. Identify the specific evidence you reviewed and considered in forming your opinion.
2. Please provide a rationale (explanation/basis) for the opinion presented.
3. State your conclusions using one of the following legally recognized phrases:
a. _____is caused by or a result of _____
b. _____is most likely caused by or a result of _____
c. _____is at least as likely as not (50/50 probability) caused by or a result of _____
d. _____is less likely as not (less than 50/50 probability caused by or a result of _____
e. _____is not caused by or a result of _____
f. _____I cannot resolve this issue without resort to mere speculation.

Issue 2 on the Request for Examination

The Request for Examination indicates that Mr. Doe is claiming SC for IHD. The requestor explains that this condition does not require an opinion concerning relationship to service, as the IHD, if found, in this case is presumed by other evidence to be SC.

Presumptive Service Connection is a C&P term based on statutes. Certain conditions may be presumed to be service-connected based on certain parameters, such as time and place of active military service. This legal consideration may have influenced the RVSR's determination that no clinical opinion from you is required for SC. Your job for this Request is to determine functional limitations resulting from this condition.

The next step is to review other evidence and clinical records that you were provided.


Issue #2: Veteran is claiming SC for ischemic heart disease (IHD). No opinion is required since this is a presumptive SC condition. Please examine Veteran, complete an IHD DBQ and determine functional limitations related to his IHD.

AVAILABLE EVIDENCE

SERVICE RECORDS: Veteran was in Vietnam from 2/1/67 to 12/1/67
PRIVATE MEDICAL RECORDS: Treatment records in C-file are tabbed and reveal treatment by Dr. Heart 1/10/2000 for MI, treated with hospitalization, cardiac cath and stent x1. Multiple follow up examinations by Dr. Heart reveals stable cardiac status.

Finish Your Review

You have accessed and reviewed the Request for Examination form, the exam worksheets, and the DBQ for Mr. Doe's exam. Before you are done, your review should include Mr. Doe's service records and all clinical records that are provided in his C-file. Additional VA clinical records might be available to you if you have access to the VA Computerized Patient Record System (CPRS). When your document review is complete, what is needed from you should be pretty clear.

Lesson Summary

This lesson walked through the process for preparing for a disability exam. Best practices call for a thorough review of all documentation that is provided to you, including the Request for Examination and the DBQs or other documentation protocols called for in the Request for Examination; and any other evidence provided to you such as past service records and private clinical records in Mr. Doe's C-file, and clinical records from VA. This lesson explained that a medical opinion is not always required, but when an opinion is required, there is specific legal language to incorporate, and any opinion must be supported by evidence and rationale.

Conduct a C&P Examination

Learning Objectives

This lesson begins as you greet Mr. Doe. As a best practice, start guiding Mr. Doe through the disability exam when you introduce yourself. In turn, you will be guided through the exam to provide all needed information by the specific items and questions on the Request for Examination and the worksheets and DBQ that you'll refer to as you work. This lesson also gives pointers on what you should or should not discuss with Mr. Doe as you close his disability exam.

The information in this lesson is intended to help you with this learning objective: Recognize best practices for opening, conducting, and closing a C&P examination.

Meet Mr. Doe

Since Mr. Doe's exam is to be an original exam, you are likely the first disability examiner that Mr. Doe has met. Start by introducing yourself as his disability examiner for this visit. Take a few moments to explain that the assessments you conduct with him today will provide clinical information for VBA to consider-along with other factors-for Mr. Doe's claim. He should be reminded that the disability exam is not an exam for prescribing or recommending treatments.

In fact, this approach is recommended for any disability exam, as many claimants still confuse disability and treatment exams. This approach helps to set the stage for both of you.

Since you will use DBQs and other documentation protocols during the exam, let Mr. Doe know that you will be using guides for his assessments to make sure that you provide the precise information needed for his claim. Moreover, Mr. Doe will probably appreciate your courtesy if you let him know he can ask questions at any time during the exam.

Mr. Doe's History

Explain to Mr. Doe that you have reviewed his records. Be compassionate and listen to Mr. Doe as you review his pertinent history with him. You will need to take a detailed history that is appropriate for Mr. Doe's General Medical Exam. His history could be extensive.

By comparison, for a compensation or pension follow-up examination, such as an increase or review exam, only an interval history is required. You may recall that this was pointed out in the description of the priority for each of these exams. You would take history from the date of the last C&P examination through the date of the current examination for those other exam priorities.

As you finish taking Mr. Doe's history, you are mentally preparing to start the physical assessments. The initial interview went well. You ask Mr. Doe if he has any questions for you. Mr. Doe reaches for his briefcase.

What follows next is not typical of every disability exam, but sooner or later you will probably deal with a similar situation.

Mr. Doe's Additional Information

Mr. Doe explains that his Veteran advocate suggested that he bring some information for you. From his briefcase, Mr. Doe pulls a recent treatment summary from his personal physician and what looks like a study on Vietnam Veterans that was printed from the Internet.

Mr. Doe asks you to add the information to his C-file. What you do and say next will depend on policies at your facility. First, review the documents that Mr. Doe brought in.

Since Mr. Doe is going to have a General Medical Exam, the information in the treatment summary he just handed to you may be useful for your report. If the treatment summary gives additional information that you can use today, you will want to cite the information in your examination report. The study on Vietnam Veterans should go directly to Mr. Doe's VBA contact without your review. You should note in the report that you explained to Mr. Doe that he must deliver or mail both the actual documents to his contact at VBA.

Given that you should never add anything to Mr. Doe's C-file, you will want to know the policy at your facility for ensuring that any document used in your report gets to the RO. For any Veteran or Servicemember-furnished information, you cannot go wrong in recommending that Mr. Doe contact VBA about adding the new information to his file so that he can answer any questions for his VBA contact and to ensure that his documents are processed at VBA.

Mr. Doe's Examination

Allow ample time to perform Mr. Doe's exam, based on the complexity and the number of conditions to be addressed for his claim.

Here are best practices for performing a C&P examination

- Follow instructions on the Request for Examination and the DBQ, worksheet, or template exactly.
- Follow the appropriate DBQ, worksheet, or template protocol for the specific examinations requested.
- Describe symptoms and findings in the terms used by the DBQ, worksheet, or template.
- Accurately document Mr. Doe's current functionality with regard to any disability at issue, as this information is especially important for rating purposes.

Your examination of Mr. Doe should be detailed and should provide a definitive diagnosis for each disease and condition assessed.

Stay within Request for Examination Parameters

Mr. Doe's Request for Examination was sent to you after a staff member at VBA thoroughly reviewed all evidence for Mr. Doe's claim and determined what information is needed from you, the disability examiner. Never presume that you have been provided with all documentation or previous evidence submitted for Mr. Doe's disability claim. Some information submitted to VBA by the Servicemember or Veteran may have lacked merit, or could be under review for another claim. Remember, you have contact information at the bottom of Mr. Doe's Request for Examination to use in case you have a question.

As it concerns Mr. Doe or any Veteran or Servicemember, if Mr. Doe asks for treatment for a non-emergent condition, recommend that Mr. Doe contact his treatment provider for treatment. This is also the correct response to Veterans and Servicemembers that present with or ask about conditions that are

unrelated to matters on the Request for Examination form or the DBQs or other documentation protocols you are using.

Note: Check the Request for Examination periodically to ensure that you are getting the right information to address all requests and questions on this form.

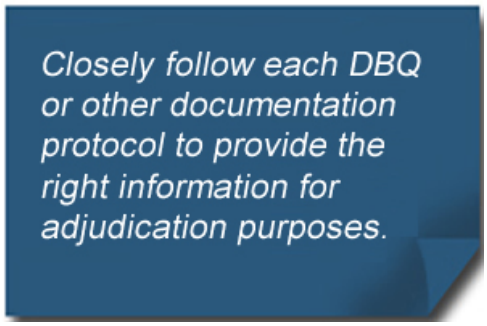
Follow the DBQ!

As you conduct the C&P exam, closely follow each DBQ or other documentation protocol listed on the Request for Examination to ensure that you provide the right information using the right terminology for adjudication purposes. You also know to stay within the parameters given in a Request for Examination.

The points of history, examination, and tests listed on the DBQ or other documentation protocol are meant as a guide to outline and emphasize the elements necessary for the appropriate adjudication of the claim for the disease or injury for which the examination is being conducted. Additional information may be necessary to establish a diagnosis for a claim. Disability examiners need to rely on their medical expertise and clinical judgment to add elements of a history, clinical examination, or tests that may be required to accurately capture or support their findings.

You should only access and use an additional DBQ or other documentation protocol if you need to provide information that is reasonably related to the existing SC/NSC disability or claimed condition on a Request for Examination.

The need to follow the Request for Examination and the DBQs or other examination protocols can be illustrated by considering what happened recently during a C&P exam for Mr. Smith.



Close the Disability Exam

As you conclude the exam, ask Mr. Doe if he has any questions. It is appropriate and helpful to provide clear instructions on what happens next—but avoid voicing legal opinions.

The points of history, examination, and tests listed on the DBQ or other documentation protocol are meant as a guide to outline and emphasize the elements necessary for the appropriate adjudication of the claim for the disease or injury for which the examination is being conducted. Additional information may be necessary to establish a diagnosis for a claim. Rely on your expertise and clinical judgment to add elements of history, clinical examination, or diagnostic tests that may be required to support your findings.

There are matters of great interest to Mr. Doe that you are the wrong person to address! Here is a short list:

- The merits of Mr. Doe's claim
- Percentage of SC disability he might be granted
- Likely outcome or benefits as a result of his examination
- Your unsolicited opinion regarding relationship of a claimed disability to service

If Mr. Doe or any other Veteran or Servicemember asks you to address the outcome of his or her claim, please explain that this is not a decision to be made by you as the examiner. Remind Mr. Doe that your role is to conduct his C&P examination and that VBA will determine the outcome and notify him in writing.

What Can You Tell Mr. Doe?

It is expected that you will give Mr. Doe a chance to discuss the exam and to ask questions. While you cannot speculate on his benefits claim, you can discuss the strictly clinical aspects of the exam and results of any diagnostic tests you conducted with Mr. Doe. You can identify diagnoses you made, or if definitive diagnosis could not be made on a condition you assessed, you could explain why not; but do remind Mr. Doe that the evaluation is just part of a larger process and his claim will not be adjudicated based on the current examination alone.

If you are ordering additional tests for Mr. Doe, let him know that additional tests are going to be scheduled and that he will be notified in order to set up necessary test appointments.

Close the appointment by explaining to Mr. Doe that you will order any additional tests needed, and complete your exam report, after the results of all tests have been received, and submit the information to the VBA contact that needs the information to adjudicate Mr. Doe's claim. Remind him that VBA will send him written notice of their determination for his claim.

Next Steps

At this point and prior to completing your exam report, you would order any tests required by the DBQs or other documentation protocols used to establish diagnoses for rating purposes, unless the diagnosis is already well-established and the tests are already done. Remember, the focus is on providing evidence as required of you, not treatment.

Please note that in some Request for Examination instructions, you will be asked to use your clinical judgment to determine whether a specific test is indicated. If, in your judgment, the test is required, then order the test and report the results.

Suicide prevention outreach is another important consideration to keep in mind when finishing a disability exam. When you interact with a Veteran or Servicemember, you should be aware of available resources for suicide prevention in this population. Select Next to learn more.

Suicide Risk in Veterans and Servicemembers

Based on information available from the Centers for Disease Control and VA, Veterans and Servicemembers die by suicide at a higher rate than the general population. As an examiner, it is important to note that Veterans or Servicemembers undergoing any transitions, including the Compensation and Pension Exam process, may be at higher risk for suicide.

Suicidal thoughts and behaviors are commonly found at increased rates among individuals with psychiatric disorders, especially major depressive disorder, bipolar disorders, schizophrenia, PTSD, anxiety, chemical dependency, and personality disorders. A history of a suicide attempt is the strongest predictor of future suicide attempts, as well as death by suicide. Intentional self-harm (i.e., intentional self-injury without the expressed intent to die) is also associated with long-term risk for repeated attempts as well as death by suicide. Additionally, the risk of suicide may increase with the severity of Veterans' and Servicemembers' war-related injuries.

All Veterans and Servicemembers who present with a history of a mental health diagnosis or with any of the suicide warning signs and risk factors should have a further suicide risk assessment which can be completed either by the examiner or by referral, secondary to the C&P examination process.

Note: All Veterans and Servicemembers, regardless of risk, should be given the Veterans Crisis Line number. A Veteran or Servicemember can reach the Veterans Crisis Line by dialing: 1-800-273-TALK (8255), and then pressing 1.

The Resources section of this document provides helpful documents to have on hand and the URL of the Suicide Prevention Resources for Providers website.

Lesson Summary

This lesson covered the general protocol and best practices for conducting a disability exam. Proactively explain your role and differentiate between the disability exam and the treatment exam to set the stage. This lesson covered aspects of the Veteran or Servicemember interview, including what to do with Veteran or Servicemember-furnished documents and which topics can be discussed. The Request for Examination and the DBQ and worksheets for Mr. Doe's exam guided your information gathering and documentation.

The last aspect of the disability exam is completion of the exam report. This step in your process as a disability examiner is the topic for the fifth and last lesson of this course.

Complete Your C&P Examination Report

Learning Objective

Note: The final exam report is primarily for legal purposes to be read and understood by adjudicators, lawyers, and judges.

You closed the C&P exam for Mr. Doe. This is a good time to work on the exam report for his claim with VBA. This lesson will cover best practices for completing a C&P examination report, including diagnosis "don'ts," and what to include when you are requested to provide an opinion in your report.

This lesson will cover best practices for preparing a complete and useable examination report. The Request for Examination and the DBQs or other documentation protocols you used will help you to structure the report. A best practice is to provide all that is asked for using the terminology suggested on these forms. Remember, the final exam report that you write is for legal purposes to be read and understood by adjudicators, lawyers, and judges, not just medical personnel.

Upon completing this lesson, you should be able to identify best practices for documenting a C&P examination for VBA and BVA adjudication purposes. Given an overview of procedures for completely documenting a C&P examination to include adequate diagnoses, descriptions of functional limitations, or medical opinions for VBA and BVA adjudication purposes.

Check for Completeness

Does your report address all claimed conditions and specific requests on the Request for Examination? Have you provided all information needed on the DBQs or other documentation protocols you used for the exam?

Additional Tests

Incorporate test results information in the exam report. Review labs, X-rays, and all other test results, and document your findings in your report.

Sign the Exam Report

The legal document that is the exam report must be signed by you before it is considered a complete exam report.

Diagnosis Don'ts

Are all of your diagnoses supported? If an examination report does not contain sufficient details to adequately support the requested diagnoses, or sufficient information about the current findings and effects on functioning, the report will be returned as inadequate for rating purposes.

Each diagnosis must be definite and useable for adjudicating the claim for which you are providing evidence.

Here are examples of how not to document a diagnosis:

- **Non-committal diagnosis:** Don't use phrases such as "differential diagnosis" or "rule out" or provide a differential diagnosis (rather than a specific diagnosis)
- **Symptoms or signs:** Don't use symptoms (pain) or signs (redness) in lieu of a diagnosis if a more exact diagnosis is known. If a disease appears to exist but an etiology cannot be determined, you may say, for example "fatigue of unknown etiology."

Opinion calling for further studies, evaluations, or laboratory tests: If further studies, evaluations, or tests are necessary, perform them before making a final decision. Otherwise the examination is incomplete and will be returned as inadequate. You should not give an opinion prior to performing and evaluating further required tests.

Employability

Did you answer all questions in the Remarks section of the Request for Examination?

Speaking of questions on the Request for Examination, follow these guidelines if you are asked to provide information about employability.

Note: When asked about employability, you should never comment on whether an individual Veteran or Servicemember is or is not individually unemployable. Instead, you should describe in full the effects of the conditions being examined on functioning, and how that relates to employment, e.g. inability to bend, lift, stoop, walk, or sit for extended periods.

If you are unsure of what kind of employability information is required of you from the Request for Examination, contact the requestor using the information at the bottom of the form before the exam begins.

Opinions

By now, you know to only give an opinion when the Request for Examination requests one. One clue is whether or not the Request for Exam form has suggested nexus statements at the end of the request.

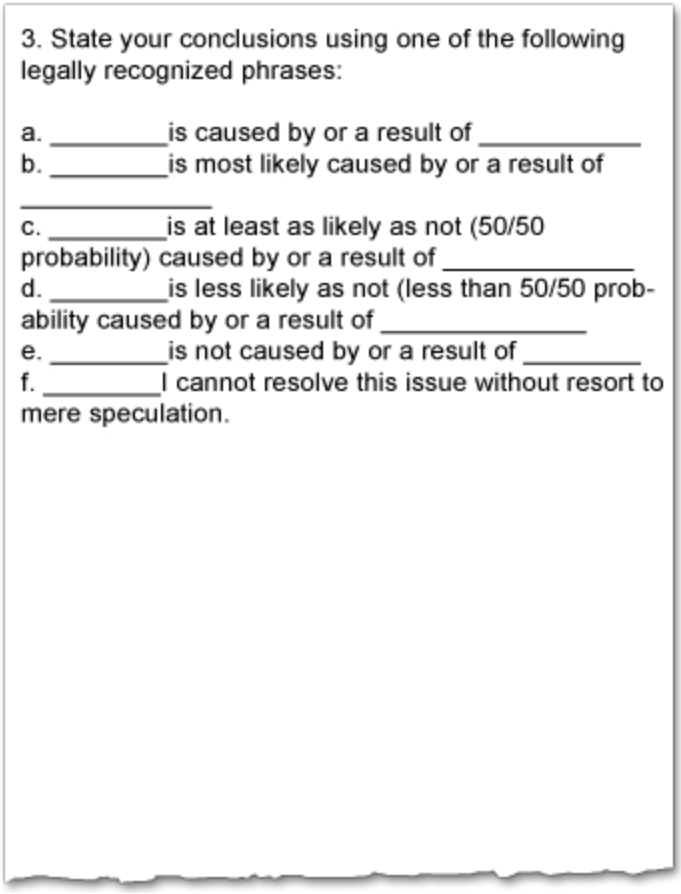
You may recall suggested legal phrases under the Request of Mr. Doe's Request for Examination. If a medical opinion is requested for a claim, you must provide one. Moreover, you should identify the specific evidence reviewed and considered in forming the opinion and provide a rationale for the opinion.

Any opinion you write must be definite. Avoid any ambiguous wording. A poorly written opinion begins with phrases like these:

"It could be..."
"It is possible..."
"Maybe..."

In fact, your opinion is negated if you use such terms. Even if you were to continue with suggested terminology such as, "...the Veteran's current medical condition is/is not at least as likely as not related to his [specific] injury during military service," the damage has been done.

A sample opinion, with all the working parts, is provided in the Resources section of this document.


3. State your conclusions using one of the following legally recognized phrases:

a. _____is caused by or a result of _____
b. _____is most likely caused by or a result of _____
c. _____is at least as likely as not (50/50 probability) caused by or a result of _____
d. _____is less likely as not (less than 50/50 probability caused by or a result of _____
e. _____is not caused by or a result of _____
f. _____I cannot resolve this issue without resort to mere speculation.

Lesson Summary

This lesson explained how the quality of your documentation determines the overall quality of the C&P examination, and the importance of including all pertinent history and exam findings required to substantiate diagnoses for all claimed conditions. It was noted that you should return to the instructions on the Request for Examination and any DBQ, template, or worksheet you used before, during, and after a C&P examination to double check that all requested information has been provided.

This lesson included the reminder that you should only provide a medical opinion when the opinion is requested, and then use the correct terminology for your opinion and include the evidence considered and the reasons for your opinion.

You have finished this required course for basic certification as a disability examiner. Before you go to the course assessment on the next page, you may review information as needed. Use the course Menu in the upper left corner to navigate to Lessons 1 through 5 for review purposes.

The Next button at the bottom of this page is active only if you completed all five lessons and all Knowledge Checks. If the Next button is not active, select the course Menu and then select Course Status to see which lessons you need to complete.

Resources

Internet and Intranet Resources

Suicide Prevention Resources for Providers:
http://www.mentalhealth.va.gov/providers/suicideprevention/index.asp

Documents

Request for Examination for Mr. J.Doe: See Appendix
Sample Opinion: See Appendix

Appendix

Appendix

Glossary

Glossary

Appendix

Suicide Risk Assessment Guide

Suicide Risk Assessment Guide (Pocket Card)
http://www.mentalhealth.va.gov/docs/Suicide-Risk-Assessment-Guide.pdf

Request for Examination for Mr. J.Doe

Sample Opinion

Glossary

A

Aggravation

A pre-existing injury or disease will be considered to have been aggravated by active military, naval, or air service, where there is a permanent increase in disability during such service, unless there is a specific finding that the increase in disability is due to the natural progress of the disease.

B

BVA

Board of Veterans' Appeals

C

CAPRI

Compensation and Pension Record Interchange, the VHA computer program that disability examiners use to document examination findings in a template or DBQ format. The CAPRI electronic documentation tool expedites claims, decreases report release days for Veterans and clinics, ensures every issue and item required is contained in the report for VBA to adjudicate the claim and is convenient for the VHA examiner since the examiner can affix their electronic signature, after review, and submit the report directly to VBA electronically upon completion.

C-file

Claims File, the folder that contains the Veteran's, Servicemember's, or claimant's STRs, claim correspondence, evidence including medical records, and documentation of all benefit awards. The Claims File is confidential and the Veteran may not have access to this claims file without the presence of an authorized VBA representative. Claims files should not be given to Veterans to carry from one clinic to another or from the Medical Center to the Veterans Service Center.

Combat Service

Claims related to combat services have significant differences, mostly on the evidentiary burden on the claimant. For claims based on combat service, satisfactory lay or other evidence that an injury or disease was incurred or aggravated in combat will be accepted as sufficient proof of service connection if the evidence is consistent with the circumstances, conditions or hardships of such service even though there is no official record of such incurrence or aggravation.

CPRS

Computerized Patient Record System, VA's electronic health record system

D

Direct Service Connection

For disability resulting from personal injury suffered or disease contracted in line of duty, in the active military, naval, or air service, compensation will be paid to any Veteran discharged or released under conditions other than dishonorable from the period of service in which such injury or disease was incurred. In other words, direct service connection is established if the Veteran's or Servicemember's current disability was caused by or resulted from his military service. When all of the evidence, including that pertinent to service, establishes that a condition was incurred in service, direct service connection can still be established even though there was no documented complaint or symptoms of the condition in service.

DBQ

Disability Benefits Questionnaire, a form designed to solicit pertinent and easily accessible medical information from treatment records to support a claim for benefits. DBQs are concise, straightforward documentation tools tailored to the VA Schedule for Rating Disabilities (Rating Schedule). A DBQ is more a forensic than clinical medical report. DBQs enable VA to access resources of the private medical community and streamline the disability examination process.

DEMO

Disability Examination Management Office, functions as a national oversight program established primarily to monitor VHA C&P performance and disability examination-related issues within VA. DEMO collaborates closely with other governmental programs and offices, such as the Veterans Benefits Administration (VBA) and the Department of Defense Integrated Disability Evaluation Program (IDES).

E

Examination Priorities from a Request for Examination

- **Original SC Examination** - An original claim to establish SC disability involves a Veteran or Servicemember who claims for the first time a condition or conditions that he or she believes is related to an injury, illness, or event that occurred during military service. When you conduct the examination, you should take a detailed history of the claimed condition or conditions from the date of onset until the present day, including any mechanism of injury. Make sure you report any diagnosis, symptoms, functional limits, and/or treatment the Veteran or Servicemember received before, during, and after military service.
- **Original NSC Pension Examination** - An evaluation of a disability resulting from a disease or injury that was not incurred or aggravated in active military service. Additional specific VBA criteria must be met.
- **Increase Exam** - An Increase exam involves an evaluation of a disability that has already been determined as SC. The Veteran believes the claimed condition(s) has worsened since the last rating examination. You should take a detailed history of the condition(s) identified in the examination request from the date of the last C&P examination until today.

- **Review Exam** - An evaluation of a disability that has already been determined to be SC. But unlike an "increase" request, VBA initiates a "review" request to determine whether or not the current disability rating is still appropriate. (NOTE: For certain disabilities that are not static, VA is required to periodically re-evaluate their disabling effects on the Veteran.) When you conduct the examination, you should take a detailed history of the claimed condition(s) from the date of the last C&P exam until today.
- **POW Exam** - Used to determine the baseline medical condition of the Veteran from his/her incarceration as a POW to the present point in time. Approach these Veterans with the greatest sensitivity because the POW experience likely resulted in a great deal of psychological and physical trauma. Each disability/disease/condition the Veteran is claiming as a consequence of the POW experience needs to be detailed, and often the C&P examiner is the first person to whom the Veteran discloses his or her experiences. Details about beatings, torture, forced marches, forced labor, diet, disease, brainwashing, extremes of hot and cold, and anxiety may be significant parts of the Veteran's history; eliciting these details requires that one establish a trusting relationship with the Veteran.
- **Terminal Exam** - Requested when the Veteran/Servicemember's prognosis is poor. A Terminal exam request requires an expedited process. Completion of the examination and report by VHA, and adjudication by VBA, is expected to be accomplished within days of receiving the Veteran's/Servicemember's claim.
- **Inadequate Exam** - An Inadequate exam is requested when a prior exam report is deemed insufficient for adjudication purposes. Examples of an inadequate exam request include, but are not limited to, these oversights: the report is unsigned: the report does not address all disabilities for which an examination was requested; exam template, worksheet, or DBQ is not fully completed; or a medical opinion was requested but not provided; or a medical opinion was provided but it either does not include a supporting rationale or the rationale provided is incomplete or otherwise inadequate.
- **Other Exam** - Two examples of other examination priorities are Appeal and BVA Remand. A Veteran or Servicemember who is dissatisfied with his or her rating decision can appeal that decision to VBA, and if the Veteran is dissatisfied with the appeal decision, he or she can continue their appeal upward to the Board of Veterans' Appeals (BVA), the U.S. Court of Appeals for Veterans Claims (CAVC), the U.S. Court of Appeals for the Federal Circuit, and finally to the U.S. Supreme Court. An appeal or remand may result in the need for an additional examination, or there may be a remand, or a request from BVA for VHA to re-examine the Veteran/Servicemember. The examiner may be asked to answer specific questions as detailed in the request.

L

Lay Evidence

Lay evidence is defined as any evidence or statements by a person without specialized education, training, or experience. In other words, this is a statement provided by someone who does not have a medical background or training, i.e. not a clinician. Generally, this evidence is provided by a person who has the knowledge of facts or circumstances and conveys matters that can be observed through the senses or via firsthand knowledge.

N

Nexus Opinion

An opinion for C&P purposes that is a thoughtful opinion based on all available evidence, supported by a logical, clearly stated rationale concerning a Veteran's or Servicemember's medical issues and their relationship to his/her eligibility for VA disability compensation or pension. C&P opinions are requested by VBA or an administrative law judge from the Board of Veterans' Appeals (BVA).

Nonservice-connected (NSC) Disability

A disability or disabilities resulting from a disease or injury that was not incurred or aggravated in active military service

Nonservice-connected (NSC) Disability Pension

A needs-based monetary benefit for wartime Veterans who are permanently and totally disabled from NSC disability or a combination of SC and NSC disabilities, not the result of their own willful misconduct.

P

Presumption of Soundness

"The Veteran or Servicemember will be considered to have been in sound condition when examined, accepted and enrolled for service except as to defects, infirmities, or disorders noted at entrance into service, or where clear and unmistakable (obvious or manifest) evidence demonstrates that an injury or disease existed prior thereto and was not aggravated by such service. Only such conditions as are recorded in examination reports are to be considered as noted." (Authority: 38 U.S.C. 1111)

Presumptive Service Connection

In the context of VA claims adjudication, there are statutes and regulations designating that, for Veterans who develop certain disabilities, that disability will be presumed to have been caused by or incurred in service. Presumptive service connection under these statutes is seen as a procedure to relieve certain Veterans of the burden to prove that a disability or illness was caused by or incurred in service.

R

Request for Examination (VA Form 21-2507)

An electronic request for a disability examination is initiated by the VA Regional Office (VARO or RO). Examinations are requested after the Veteran or Servicemember has made a substantially complete application for disability benefits. The examination request should be reviewed in detail by the disability examiner prior to conducting the requested examination.

RO

Regional Office, a field office of the VBA which adjudicates claims to VA for benefits and delivers other services to Veterans or Servicemembers. Also known as the VA Regional Office, or VARO.

RVSR

Rating Veterans Service Representative, a VBA employee who, based on service and medical records, determines whether or not a claimed disability exists, the relationship of the disability to military service, and the degree to which it renders the claimant disabled

S

Schedule for Rating Disabilities (38 Code of Federal Regulations, Part 4)

VA's Schedule for Rating Disabilities is a guide in the evaluation of disability resulting from all types of diseases and injuries encountered as a result of or incident to military service. The ratings represent the average impairment in earning capacity resulting from such diseases and injuries and their residual conditions in civil occupations. Generally, the degrees of disability specified are considered adequate to compensate for considerable loss of working time from exacerbations or illnesses proportionate to the severity of the several grades of disability. For the application of this schedule, accurate and fully descriptive medical examinations are required, with emphasis upon the limitation of activity imposed by the disabling condition.

Secondary Service Connection

An additional disability, which is proximately due to or the result of a SC disease or injury shall be SC. Additionally, any increase in severity of a NSC disease or injury that is proximately due to or the result of an SC disease or injury, and not due to the natural progress of the NSC disease, will be SC. However, VA will not concede that an NSC disease or injury was aggravated by an SC disease or injury unless the baseline level of severity of the NSC disease or injury is established by medical evidence.

Service-Connected (SC) Disability Compensation

Refers to monetary benefits paid to Veterans or Servicemembers who are disabled by SC conditions (conditions related to military service). SC disability compensation benefits are intended to compensate for average loss of earning potential due to a current disability resulting from disease or injury which was incurred or aggravated (pre-military conditions) in active military service.

STR

Service treatment records

V

VARO

VA Regional office (See RO)

VBA

Veterans Benefits Administration, the administration responsible for a wide variety of benefit programs authorized by Congress, including disability compensation, disability pension, burial assistance, rehabilitation assistance, education and training assistance, home loan guarantees, and life insurance coverage.

VHA

Veterans Health Administration - VHA is the administration that provides health care for Veterans through nationwide VA Medical Centers (VAMCs). VHA manages one of the largest health care systems in the United States. VAMCs within a Veterans Integrated Service Network (VISN) work together to provide efficient, accessible health care to Veterans in their areas. VHA conducts research; is among the largest providers of health professional training in the world; is a principal Federal asset for providing medical assistance in major disasters; and serves as the largest direct-care provider for homeless citizens in the United States.

VSC

Veterans Service Center, a field office of the VBA that adjudicates claims to VA benefits and delivers other services to Veterans.

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